

**CAP-MR/DD WAIVER TRANSITION  
QUESTION AND ANSWER #13  
September 16, 2005**

TOPIC	QUESTION	RESPONSE
Home and Community Supports	We have a CAP consumer that resides in an assisted living facility, but receives CAP services from an outside provider. The assisted living facility is not interested in enrolling to become a CAP provider to provide the residential support service. The outside CAP provider is not able to bill the residential supports in this setting because it is not their facility. The provider comes in and helps the individual with his training needs. Can the outside provider provide Home and Community Supports in this setting? Please advise.	Individuals in this setting would only be able to use the community component of HCS in order to meet their day programming needs. Residential Supports is intended to meet the habilitation, personal care, and support needs of individuals in licensed residential settings or unlicensed AFLs.
Residential Supports	It is my understanding that local approvers were told that they could approve CAP plans that simply converted Supported Living to Residential Supports with the understanding that at the CNR the plan would be written to include all the components of the new definition(s). Please explain, and please address issues of documentation, forms, etc.	The new definition of Residential Supports includes personal care, habilitation, and support components. This therefore requires that personal care tasks be included within the Plan of Care. Personal care tasks must be added to the Plan of Care during this transition time, however, it is not necessary for these to be sent through local approval. They will be fully reviewed at CNR. In addition, a new grid has been posted to the Division website that includes both the habilitation components and the personal care components of the service definition.
Residential Supports/Personal Assistance for MR/MI	Have agencies been given approval to continue to use Personal Assistance in conjunction with Residential Supports and under what conditions?	Yes. This is currently being reviewed at the Division and until further guidance is provided the use of PA may continue.

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CSHS/Wheelchairs	<p>The Children's Special Health Services (CSHS) Program is the prior approval reviewer for wheelchair requests for children under 21 who are Medicaid eligible. The current administrative procedure requires that the local CAP/MR-DD case manager sign the "3056" DHHS authorization request form before the request can be approved. This procedure was developed to monitor budget expenditures and to force communication between those requesting wheelchairs (therapist, physician and DME provider) and the case manager for coordination of care. It has been helpful in the respect that the case manager has to be contacted and informed thus assuring that the case manager is aware of their client's wheelchair needs and caregiver participation with the selection and usage. The notification of the case manager also helps with assisting caregivers with repair or compliance problems. Medicaid DME policy #5A has a statement regarding coordination of wheelchair and other DME items requested from the Medicaid fee schedule with local case managers for clients enrolled in waiver programs.</p> <p>In light of the new guidance in the manual in regards to expenditures billed to Medicaid not having to be included in the cost summary, does the above procedure need to be continued?</p>	<p>Although it is no longer a requirement that these items be placed on the Cost Summary, it is required that any and all services, especially equipment, be tracked and included in the Plan of Care. This process will continue.</p>
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Enhanced Personal Care	<p>Concerning the new Enhanced PCS Program:</p> <p>What qualifications, etc. are required to complete the training?</p> <p>Does it have to be Board of Nursing approved or can the agency nurse simply do the training and document accordingly?</p> <p>Does it have to be a CNA or CNA II?</p> <p>Are there written guidelines available?</p>	<p>Qualifications of staff providing Enhanced PC are outlined in the Provider Qualifications section of the waiver and draft Manual. Additional training needs of staff that are providing enhanced PC are based on the individual needs of the consumer. The intent is that staff providing the service will have any client specific training needed to ensure that they are competent to provide the supports to the individual based on the intensity of their need around medical or behavioral challenges.</p>
Enhanced Personal Care	<p>If an individual is requesting enhanced respite or enhanced personal care, what is the maximum number of hours for each of these services?</p>	<p>There is no specified number or limitation on hours. Services must be based on the needs identified in the NC-SNAP, and person centered Plan of Care.</p>
Plan of Care	<p>Do we need to include dosage, route, and schedule of medications on the plan of care on page 2 under the Medications sections?</p>	<p>No.</p>
Targeted Case Management	<p>Is a formal goal for Targeted Case Management needed in the ("Action Plan") Plan of Care or does the "Case Management/Service Monitoring Plan" page (next to last page of plan) take care of this?</p>	<p>There must be case management outcomes listed in the Action Plan; these may be very broad to reflect the primary components of case management.</p>
Targeted Case Management	<p>Please clarify the endorsement issue regarding Targeted Case Management. Per the August Medicaid Bulletin, it states that providers should work with the LME's to get endorsed by 12/31/05. Other memos have been floating around the internets stating that endorsement for this service will not start until 4/06.</p>	<p>Endorsement for the Enhanced Benefit service of TCM falls within Phase II (December-February) of the Endorsement Transition Plan.</p>

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	This is important as per endorsement trainings that have been attended, the endorsement process is detailed and timely (best case scenario, it should take several weeks from start to finish). Then there is the time required for Medicaid enrollment.	
DME/Diapers	Q & A 8/18/05 mentions diapers are billed as T1999. Diapers are a regular Medicaid item found on the home health list and should be billed under those regular Medicaid codes, not a miscellaneous code or T1999, right? With the new cost summary, these shouldn't be reflected there, only on the plan.	You are correct; the 8/18/05 Q & A was incorrect on this issue.
Day Supports	If a school aged child is attending developmental day (as their IEP) school, can you also bill day supports? Presently they bill developmental day..	Developmental Day is no longer a waiver service; Developmental Day is now billed under Day Supports.